Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAMIR S EBEADE, MD PA
3009 MACARTHUR DRIVE
ORANGE, TX 77630

Respondent Name

COMMERCE & INDUSTRY INSURANCE

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0031-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "$650 is in accordance with Fee Guidelins [sic] Carrier maintains $500 in Fee Schedule."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on September 06, 2011 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 21, 2011	99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation(s) of benefits dated May 26, 2010, June 06, 2010, and August 15, 2010
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - VRNA – No Reduction Available
   - Z710 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Has the Maximum Medical Improvement/Impairment Rating (MMI/IR) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor rendered the DD exam as ordered by the Division. The provider billed the amount of $650.00 for CPT code 99456-W5-WP for a MMI/IR examination. Review of the documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions is reviewed. Documentation supports the non-musculoskeletal rating of sensations of the median nerves in the left wrist per the use of AMA Guides to the Evaluation of Permanent Impairment, 4th Edition using Table 11, Page 3/48 and combined with Table 15, page 3/54. Per 28 Texas Administrative Code §134.204(j)(4)(D)(iv) and (v) the MAR is $150.00. The combined MAR for the MMI examination and the IR is $500.00 which has already been reimbursed.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 28, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.